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G 000	INITIAL COMMENTS Surveyor: 22116 This Statement of Deficiencies was generated as a result of the Medicare re-certification survey under 42 CFR Part 484 - Home Health Services, conducted at your agency from 9/21/09 through 9/24/09. The active census on the first day of the survey was 58. Eight clinical records were reviewed, including two closed records. Two home visits were conducted. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified.	G 000		
G 121	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. This STANDARD is not met as evidenced by: Surveyor: 22116 Based on the Nurse Practice Act, record review and staff interview, the agency failed to ensure care was provided in accordance with accepted standards of practice, for 2 of 2 insulin dependant diabetic patients who were unable to provide safe self care and who had no willing or able caregiver (Patients #1, #8).	G 121		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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G 121	Continued From page 1 Findings include: The Nurse Practice Act, revised 2007, 632.216; Care of Patients; "additional duties (c) The evaluation of a patient's health and the initiation of acts which are necessary to provide adequate care to a patient when needed, giving direct care to a patient, assisting with the care of the patient or delegating the care of the patient to persons qualified to provide that care." Patient #1 The patient was admitted to home health care on 2/14/09 and discharged on 4/21/09, when it was determined he was no longer home bound. His admitting diagnoses included uncontrolled diabetes, hypertension, chronic obstructive airway disease. His admission assessment also identified he had some cognitive deficiencies, such as impaired decision making and was confused on a daily basis. Patient #1 lived with his wife. Documentation indicated that although Patient #1's wife was assisting with Patient #1's daily oral medication regime, she no longer wanted to assist with his insulin management because Patient #1 was in the wife's words "noncompliant nor cooperative with care." The physician's orders instructed the home health agency to provide twice a day skilled nursing visits for diabetes and insulin management. Patient #1 was on Novolin insulin sliding scale management during the day and Lantus insulin 34 units to be be administered every evening at bedtime. Documentation in the initial assessment	G 121		

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G 121	Continued From page 2 indicated, "patient is unable to properly administer own insulin safely, adequately or correctly." Documentation for the two certification periods of care revealed Patient #1 was being seen by skilled nursing twice a day, every morning and mid afternoon. Documentation in the skilled nurses visit notes were consistent with identifying there was no willing and capable caregiver to check blood sugars and administer the insulin to Patient #1. Documentation was consistent that Patient #1 had vision and cognitive impairments that prevented him from being able to administer his insulin during the day. Documentation was consistent that although the skilled nurses prepared and administered the sliding scale insulin coverage required for Patient #1, the nurse also prepared and left the 34 unit Lantus insulin for Patient #1 to self administer at bedtime. There was no evidence in the documentation that any of the nurses evaluated Patient #1's ability to administer his own insulin. An interview with Employee #3, confirmed she was the admission nurse and one of the nurses who provided care to Patient #1 during his home health services. Employee #3 stated that upon admission to home health care, Employee #3 recognized Patient #1 used poor technique with testing his blood sugars and administering his insulin. Specific examples that Employee #3 provided was that Patient #1 would: - reuse lancets and needles/syringes - would not use alcohol wipes to clean his skin - would lick his finger to clean it before a fingerstick - leave used needles/syringes and lancets lying about, not discarding them.	G 121		

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G 121	Continued From page 3 Employee #3 confirmed: - she did not have Patient #1 administer any of the sliding scale insulin doses that were administered during her visits - she did not evaluate Patient #1's ability to properly administer his evening doses of insulin - the wife refused to assist with insulin administration - Patient #1 had not been assessed to confirm whether he was able to safely administer his evening dose of Lantus insulin. Patient #8 This patient was admitted to the agency on 7/16/09, and was currently being seen, in his second recertification period. His admitting diagnoses included uncontrolled diabetes, with circulatory and visual complications. The physician's orders were for daily skilled nursing visits. Other orders included blood sugars to be done three times a day. The clinical record revealed that although Patient #8 lived with family members, there was no consistent, willing and able caregiver available to assist with his diabetic/insulin management. The admission assessment documented that although family members were present, they were unwilling to assist with Patient #8's diabetic medication regime because they "were afraid of hurting him," they were out of state or country on a weekly basis, or they were not mentally capable of being taught. Documentation of skilled nursing visits revealed the nurse did go every evening to administer Patient #8's 15 units of Lantus insulin. There was no evidence in the charting of what Patient #8's blood sugars were except the one the skilled	G 121		

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G 121	Continued From page 4 nurse performed.	G 121		
G 145	484.14(g) COORDINATION OF PATIENT SERVICES A written summary report for each patient is sent to the attending physician at least every 60 days. This STANDARD is not met as evidenced by: Surveyor: 22116 Based on interview with agency staff and review of clinical records, the agency failed to ensure the written summary to the physician met the regulatory definition of a summary for 4 of 8 records reviewed of patient care longer than one certification period (Patients #1, #8, #2, #7). Findings include: Patient #1 The patient was admitted to home health care on 2/14/09, and discharged on 4/21/09, when it was determined he was no longer home bound. His admitting diagnoses included uncontrolled diabetes, hypertension, chronic obstructive airway disease. His admission assessment also identified he had some cognitive deficiencies, such as impaired decision making and was confused daily. Patient #1 lived with his wife. Documentation indicated that although Patient #1's wife was assisting with Patient #1's daily oral medication regime, she no longer wanted to assist with his insulin management since Patient #1 was in the wife's words "noncompliant nor cooperative with care." The physician's orders instructed the home health agency to provide twice a day skilled nursing	G 145		

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G 145	Continued From page 5 visits for diabetes and insulin management. Patient #1 was on Novolin insulin sliding scale management during the day and Lantus insulin 34 units to be be administered every evening at bedtime. Patient #1's clinical record revealed it contained a 60 day summary and a discharge summary. The 60 day summary problems identified at start of care and summary of care/progress towards goal were not divided between the two time periods and difficult to determine which statements belonged to which section. This was the documentation: "patient's blood sugar uncontrolled, patient not compliant, not motivated with treatment regime, blood pressure elevated, patient on multiple medications, patient's blood pressure unstable. Skilled nursing continues to check patient's blood sugars, pressure and administer insulin every visit. Patient non compliant, not motivated with care." There was no evidence of what ranges Patient #1's blood sugars or blood pressures were, or what was done with his "unstable" blood pressure. The summary did not include any information or progress reports from other services that were involved during the past 60 days; physical therapy, social services or certified nursing assistants. A discharge summary written on 4/21/09, was part of the OASIS discharge assessment. The following was the agency's discharge summary: "Pt's blood pressure still fluctuates, gets elevated at times. Patient no longer homebound." There was no evidence of how frequently Patient #1 was being seen, or by what services. There was no documentation of what ranges Patient #1's blood	G 145		

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pressures were fluctuating between. There was no documentation of the status of Patient #1's compliance with his diabetic management or why he was no longer homebound.

An interview with the Director of Nursing (DON) on 9/22/09, revealed Patient #1 was discharged because the agency found out that he was driving to the store to get cigarettes.

Patient #8

The patient was admitted to the home health agency on 7/16/09, with the primary diagnoses of uncontrolled diabetes mellitus (DM). Patient #8 was legally blind. He had no willing or able caregiver to perform finger stick blood sugars or to administer his insulin. Other diagnoses included osteoarthritis, diabetic neuropathy, and general weakness.

The 60 day summary dated 9/21/09, contained the following documentation: "Patient was admitted to home health for uncontrolled DM, pain exacerbations. Patient has received skilled assessment and teaching regarding complications with medication, diet, fall precautions and (word illegible) for pain management. Wife in Mexico and California on weekly basis, son unable to do Insulin injections and blood sugar checks due to (son's) mental status."

There was no documentation to reflect how frequently Patient #8 was being seen by skilled nursing or his progress towards self management of his diabetic regime. There was no range summary of what Patient #8's blood sugars were or who was performing the ordered blood sugars

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G 145	Continued From page 7 during the day. There was no summary of the other services involved (physical therapy) or Patient #8's progress. Patient #2 The patient was admitted to the agency on 3/14/09, with the primary diagnoses of hypertension, and urinary tract infection following an acute care hospitalization. He was discharged on 3/31/09. The discharge summary as part of the OASIS discharge assessment was: "Skilled nursing seeing patient for skilled assessment, evaluation of all body systems with emphasis on respiratory status,vital signs have been stable with no episodes of exacerbation, pulse oximetry within normal levels. Deep breathing exercise also explained Educated on importance of taking meds at right time, dosage and to watch for risks or adverse reactions." The discharge summary did not address either of Patient #2's primary diagnoses of hypertension or urinary tract infection. There was no evidence in the summary of what Patient #2's blood pressure ranges were. There was no documentation of medication changes, including an antibiotic that was ordered during this recertification period. An interview with the DON on 9/22/09, revealed Patient #2 had requested, as a personal choice, to be transferred back to a previous home health agency. The DON also confirmed the physician's discharge order indicated Patient #8 refused services, instead of his choice of requesting another home health agency. The DON acknowledged this could have been added to the discharge summary.	G 145		

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G 145	Continued From page 8 Patient #7 The patient was admitted to the agency on 6/29/09, following an acute care hospitalization status post a hip fracture. His primary diagnoses included osteoarthritis, and abnormality of gait. On admission, Patient #7 was determined to have a blister/pressure ulcer on his right heel. Patient #7 was seen daily through 7/6/09. The frequency was then three times a week for one week and then twice a week for two weeks. The week of 7/26/09, the frequency was to be once a week for the remaining of the recertification. On 7/28/09, the frequency was increased to every three days, because of development of a left heel wound. The clinical notes also indicated the right heel wound had increased from 2.75 centimeters (cm) by 3.0 cm to 3.5 cm by 2.8 cm during this same period of time. Review of the clinical record revealed the 60 day summary consisted of, "Wound care per MD order, instructed patient regarding disease process, meds, diet and safety." The summary did not include any summary of physical therapy, the various wound care regime changes or the occurrence of a left heel wound, and there was no summary of the wound sizes or status.	G 145		
G 165	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. This STANDARD is not met as evidenced by: Surveyor: 22116 Based on clinical record review, the agency failed	G 165		

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G 165	Continued From page 9	G 165		

to ensure the physician's plan of care regarding teaching with each skilled nurse visit was followed for 1 of 8 patients (Patient #8), and failed to follow the ordered frequency of visits for 2 of 8 patients (Patients #6 and #3).

Findings include:

Patient #8

This patient was admitted to the agency on 7/16/09, following a physician visit. His primary diagnoses included uncontrolled diabetes, diabetic neuropathy, and osteoarthritis. Patient #8 was legally blind.

The plan of care dated 7/16/09, directed the skilled nurse to perform daily skilled nurse visits. The skilled nurse was to instruct the patient and/or caregiver on pain control measures, diet, administration of injections, diabetic home management, signs and symptoms (s/s) of hypo/hyperglycemia, and action to be taken, infection control measures, new or changed medications, action or use/dose/route/frequency. Activity pacing for energy conservation, breathing exercises,/pursed lip breathing, monitoring blood sugar, disease process/management, s/s to report, s/s of exacerbation, home safety/emergency plan, foot care, proper disposal of sharps/needles, s/s of hypo/hypertension.

Review of the clinical record revealed from 8/11/09-9/13/09, there was no teaching documented by the skilled nurse.

Patient #6

The patient was admitted to the agency on

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8/19/09, with an initial skilled nursing frequency of twice a week for two weeks. On 8/25/09, seven days after admission, a wound on Patient #6's back required a change in the nursing frequency to daily care. The physician's orders in the clinical record indicated that on 8/25/09, skilled nursing was to continue daily to 9/1/09, and then re-evaluate. On 9/1/09, skilled nursing was to continue daily visits to 9/8/09, and then re-evaluate. On 9/13/09, the skilled nursing frequency was changed to twice a week for two weeks.

Review of the clinical record revealed Patient #6 was seen daily from 8/25/09 to 9/11/09. There was no order for daily visits after 9/8/09. There was no evidence of any communication with the physician requesting the additional three daily visits.

Patient #3

The patient was admitted to the agency on 8/17/09, following an acute care hospitalization. Her primary diagnoses included diabetes, hypertension, muscle weakness and Alzheimer's disease.

Patient #3 was ordered to have occupational therapy. Patient #3 was evaluated by occupational therapy on 8/25/09 (per patient request). Physician's orders were for occupational therapy to treat Patient #3 at a frequency of one time a week for one week and then twice a week for three weeks. The frequency schedule would have ended on 9/12/09. Review of the clinical record revealed Patient #3 was seen for an additional visit on 9/19/09, when she was discharged from the

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G 165	Continued From page 11 occupational therapy service. There was no evidence in the clinical record of any communication or orders from the physician for the additional visit.	G 165		
G 323	484.20(c)(1) TRANSMITTAL OF OASIS DATA The HHA must electronically transmit accurate, completed, encoded and locked OASIS data for each patient to the State agency or CMS OASIS contractor at least monthly. This STANDARD is not met as evidenced by: Surveyor: 22116 Based on documentation review and staff interview, the agency failed to electronically transmit OASIS data for each patient the agency provided services, at least monthly. Findings include: Review of Error Summary Report by Home Health Agency revealed the following: Error #286 which was, agency "Inconsistent MOO90/Submission date: The submitted assessment was not submitted within CMS timing guidelines. The submission date is more than 30 days from the M0090 (completion date). The agency had 528 submissions with this error. The % of Assessments with this Error was 67.61%. The % error rate should be no more than 15%." An interview with Employee #5 on 9/24/09 at 12:00 PM, revealed he was submitting OASIS data since 1998. He stated he submitted data every two to three weeks. He was not aware that the warnings he was receiving regarding Error 286 were so high of a percentage. An interview with the Administrator at 2:00 PM on	G 323		

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G 323	Continued From page 12 9/24/09, revealed that charts and OASIS information were being held until all patient visit notes and other data were turned in before the OASIS data was given to Employee #5 to submit.	G 323		
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Surveyor: 22116 Based on record review and interview, the agency failed to ensure the clinical record included a review of all medications currently being used by a patient with the correct dose, time and/or frequency of administration, as well as updating the medication profile with changes as medications were added or discontinued, for 4 of 8 patients (Patients #8, #2, #4, #5). Findings include: Patient #8 The patient was admitted to the agency on 7/16/09 following a physician visit. His primary diagnoses included uncontrolled diabetes, diabetic neuropathy, osteoarthritis. His admission medication profile revealed he was to take 15 units of Lantus insulin every evening. The plan of care for 7/16/09-9/13/09, did not include the specific instructions that the Lantus insulin was to be administered in the evening.	G 337		

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G 337	Continued From page 13 The clinical record revealed Patient #8 had a change in medication on 8/12/09. His Gabapentin was changed from one tablet of 300 milligrams (mg) to two tablets. This change was not added to the patient's medication profile. Patient #2 The patient was admitted to the agency on 3/14/09, with the primary diagnoses of hypertension and urinary tract infection. Review of Patient #2's medication profile identified that he was prescribed an antibiotic, Levaquin 750 mg, which began on 3/12/09 and to continue daily for 10 days. There was no documentation on the medication profile when the medication was completed. An entry on the medication profile dated 3/30/09, indicated another antibiotic was started. Patient #2 was begin Cipro 250 mg daily. There was no documentation that this antibiotic was to continue for three weeks, although this course was documented in the nurse's notes. Patient #4 The patient was admitted to the agency on 9/10/09, following an acute care hospitalization for an infected toe and venous thrombosis. Patient #4's medication profile at the time of admission revealed he was taking Cipro 500 mg twice a day for 10 days with the last dose to be finished 9/19/09. Patient #4 was also taking Warfarin (Coumadin) 4 mg daily at bedtime. An order in the clinical record revealed the	G 337		

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G 337	Continued From page 14 patient was not to take Warfarin for two days (9/14/09 and 9/15/09) then restart Warfarin at the same dose of 4 mg for six days. The clinical record revealed the last skilled nursing visit was 9/17/09, three days after the order to hold the Warfarin. A home visit was performed on 9/22/09. A review of Patient #4's medication and his medication profile list in the home revealed the following: - Patient #4 still had four capsules of the Cipro left in the bottle. Examination of the bottle revealed the pharmacy had dispensed 24 pills instead of 20. There was no evidence the physician was informed. Patient #4 stated his nurse told him to take all the antibiotics. - The medication profile was not updated to reflect that Patient #4 was not to take the Warfarin for the two days and then resume the same dose for six days, although a skilled nursing visit ws made during this interval. An interview with the registered nurse, Employee #6, during the home visit confirmed the nurse was aware of the additional antibiotics and told the patient to take all the pills. Employee #6 also confirmed he did not add the changes to the Warfarin on the medication profile because he put a copy of the order in the patient's home health information packet. Patient #5 The patient was admitted on 9/17/09, with a primary diagnosis of cerebral-vascular accident. The medication profile and the medications on the plan of care indicated Patient #5 was currently taking 11 medications. The medications were Carvedilol, Pepcid, Lisinopril, Zocor, Advair,	G 337		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297129	A. BUILDING _____ B. WING _____	09/24/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR SUPPORT SERVICES	7975 WEST SAHARA AVENUE, #101 LAS VEGAS, NV 89117

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G 337	Continued From page 15 Nicotine patch, Cozaar, Hydrochlorothiazide (HCTZ), Nitroglycerin, enteric coated Aspirin, and Plavix. A home visit conducted on 9/23/09 revealed Patient #5 was only taking four of the above medications, Carvedilol, Lisinopril, Nitroglycerin,and Plavix, as ordered on the plan of care. Patient #5 revealed during the home visit she only took the Advair as needed, not twice a day as listed on the plan of care. Patient #5 also acknowledged she was only taking the Lisinopril once a day instead of twice a day as the prescription indicated. Patient #5 acknowledged she had not yet received the prescriptions for the other medications (Pepcid, HCTZ, enteric coated Aspirin and Nicotine patch).	G 337		